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FORWARD

Planning for prevention of Human Immunodeficiency Virus (HIV) has been an integral part of programs at the South Carolina Department of Health and Environmental Control (DHEC) STD/HIV Division for more than 19 years. Since the first reported cases of HIV/AIDS in 1985, DHEC has been involved in conducting activities to address the prevention needs of those most at risk of infection.

Starting in January 1994, DHEC organized a statewide HIV prevention community planning group (CPG). In a shared effort with DHEC, the CPG developed a statewide plan to improve prevention efforts by strengthening the scientific basis, community relevance, and population or risk based focus of prevention interventions. During 2004, DHEC and the CPG have been involved in developing a new plan. This new comprehensive SC HIV Prevention Plan is the result of the efforts of many dedicated individuals who have worked to assess HIV prevention needs and to prioritize populations and interventions.

DHEC and the CPG have been fortunate to participate in a process that involves so many individuals concerned about the health and well being of South Carolina's citizens. It is the hope of DHEC and the CPG that local prevention providers and others will find this a useful and relevant document for planning local activities and efforts. We also believe that through the ongoing efforts to work together and collaborate that we can make a difference in the future of this epidemic. We believe that by TEAMwork, Together Everyone will Achieve the Mission of eliminating HIV.

ACKNOWLEDGEMENTS

We gratefully acknowledge the following members of the South Carolina HIV Prevention Community Planning Group during 2003- 2004 that contributed their time, expertise and advice to make this plan possible.

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KEY TO ABBREVIATIONS AND ACRONYMS

AA	African Americans
AAMSM	African American Men who have Sex with Men
AED	Academy for Educational Development
AHED	AIDS Health Educator (SC DHEC)
AIDS	Acquired Immunodeficiency Syndrome
ASO	AIDS Service Organization
ATOD	Alcohol, Tobacco, and Other Drugs
BRFSS	Behavioral Risk Factor Surveillance System
CBCT	Community Based Counseling and Testing
CTS	Counseling and Testing Services
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CLI	Community-Level Intervention
CPG	SC HIV Prevention Community Planning Group
DAODAS	Department of Alcohol and Other Drug Abuse Services
DEF	Data Entry Form
DHEC	Department of Health and Environmental Control
DIS	Disease Intervention Specialist (SC DHEC)
DOC	Department of Corrections
EPI	Epidemiologic
GHS	Greenville Hospital System
GLI	Group-level Interventions
GMOC	Gay Men of Color
HARSS	HIV/AIDS Reporting Surveillance System
HBCU	Historically Black Colleges and Universities
HC/PI	Health Communications and Public Information
HE/RR	Health Education/Risk Reduction
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
ILI	Individual-level Intervention
IPF	Implementation Planning Form
LIP	Local Implementation Plan
MCBO	Minority Community Based Organization
MIS	Management Information Systems
MUSC	Medical University of South Carolina
MSM	Men who have Sex with Men
MSM/IDU	Men who have Sex with Men/Injecting Drug User

MSW	Men who have Sex with Women
NIR	No Identified Risk
OUT	Outreach
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
PEMS	Program Evaluation Monitoring System
PSA	Public Service Announcement
SCDC	South Carolina Department of Corrections
SCSU	South Carolina State University
SDE	State Department of Education
STD	Sexually Transmitted Disease (synonymous with STI)
STI	Sexually Transmitted Infection (synonymous with STD)
TA	Technical Assistance
USC	University of South Carolina
WAR	Women at Risk
WSM	Women who have Sex with Men
YAR	Youth at Risk
YRBS	Youth Risk Behavior Survey

EXECUTIVE SUMMARY

The HIV/AIDS epidemic continues to impose a significant presence on citizens and on the health care system in South Carolina. In the southeastern states, HIV/AIDS has followed the patterns of other sexually transmitted infections (STIs). Sexually transmitted infections, including HIV, account for over 90% of all reported infectious diseases in the state. South Carolina ranked seventh highest in the country in 2002 for annual AIDS case rates, tenth for infectious syphilis, third for gonorrhea, and eighth for chlamydia. Over $70 million was spent in 2003 in South Carolina for HIV related medical care.

African Americans bear a disproportionate burden of the HIV and infectious syphilis epidemics in South Carolina. African Americans make up more than 70% of persons living with HIV and 85% of persons with syphilis. Such disparities are due, at least in part, to the fact that African Americans are likely to seek care in public clinics that report STD more completely than do private providers; however, reporting bias does not fully explain differences in infection rates among African Americans, particularly with HIV/AIDS.

While being African American is not in itself a risk factor for HIV and STDs, there is a positive correlation between being African American and primary health status influencing factors such as poverty, access to quality health care, health care seeking behavior, illicit drug use, and living in communities with high prevalence of sexually transmitted diseases.

Public health and community efforts have made progress in changing the course of HIV and STD epidemics, resulting in declines in the number of deaths due to HIV and decreases in the number of perinatal HIV infections. Infectious syphilis cases have continued to decline over the past eight years. Routine screening for chlamydia and gonorrhea in young sexually active women is resulting in small declines in prevalence of these diseases, and may be contributing to recent declines in hospital and emergency room visits for pelvic inflammatory disease.

Fewer HIV deaths, along with stable rates of new infection, means there are more people living with HIV who are in need of both care and prevention services. South Carolina has experienced an increase of 72% in persons living with HIV/AIDS from 1995 to 2003. More dramatically, there has been an increase of 97% in the number of women living with HIV during this time. As of December 31, 2003, there were an estimated 13,221 persons living with HIV/AIDS in the state.

Even though the overall number and rate of newly diagnosed persons with HIV/AIDS each year appears to be generally stable, it is unacceptably high. Each year an average of 880 persons are newly diagnosed with this disease. However, this number represents only those persons who have been tested. Many persons with high-risk behaviors have not yet chosen to be tested, and many persons at highest risk are not yet reached by our prevention efforts and do not seek diagnosis and treatment.

Prevention needs are essential, as persons living with HIV/AIDS are engaging in sexual and/or substance use risk behaviors. Interviews from July 2002 through March 2004 with recently

diagnosed persons with HIV indicate that one third reported substance use during the past five years, 30% reported being potential alcoholic, and 40% used illicit drugs. Nine percent reported that they had ever injected drugs and 16% had used crack. More men than women reported each substance use-related risk.

Sexual risks reported by HIV infected persons interviewed indicate that 36% of men paid someone for sex; 15% of women received either money or drugs for sex. Thirty-eight percent of men and 23% of women reported having at least one sexually transmitted disease during the past ten years.

Needs assessment with prevention providers and persons with HIV or at risk for HIV have identified priority interventions that will reduce new infections. These include needs for information for high-risk groups who do not access community/agency services (unemployed, out of school); additional programs targeting men who have sex with men; targeted peer education programs for youth and young adults; improved access to drug treatment and prevention counseling for alcohol/other drug using persons; increased numbers of trained staff that can conduct effective interventions particularly for men who have sex with men and for persons living with HIV disease.

Effective interventions to prevent HIV must be increased, integrated with STD prevention efforts, and involve leaders and members of African American communities. Additionally, care and prevention efforts must be integrated, so that the risk of transferring HIV to others from those already infected is reduced and the number of persons living with HIV who are in a system of care is increased.

Finally, for each of its priority populations, the statewide HIV Prevention Community Planning Group identified needs for more behavioral risk data, social network information and needs assessment information involving members of priority populations that will result in better decisions for planning, designing interventions, and targeting resources.

No single agency or community organization can reduce the racial and ethnic disparities in HIV infection among African Americans without the active involvement of more African American leaders and institutions. Addressing and overcoming barriers will take time, and will require effective and proven strategies along with sustained community mobilization in which community based organizations across South Carolina collaborate to address HIV/AIDS prevention priorities comprehensively and completely.